Arizona Department of Health Services Division of Behavioral Health Services PROVIDER MANUAL

Section 3.7 Clinical Liaison

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3.7.1 Introduction

ADHS/DBHS has adopted a service delivery model that includes a team-based, collaborative and coordinated approach to intake, assessment and service planning (See Section 3.9, Intake, Assessment and Service Planning). The provision of clinical input and supervision is recognized as one of the critical functions needed to support this overall approach for delivering behavioral health services. In order to enhance the effectiveness and to improve the consistency of clinical input and supervision within the behavioral health system, each enrolled person will be assigned a clinician (known as a Clinical Liaison). The Clinical Liaison's primary responsibility will be to provide clinical expertise to the team and to serve as a point of contact and communication, while working in congruence with the team process.

3.7.2 References

The following citations can serve as additional resources for this content area:

- **AHCCCS/ADHS Contract**
- ADHS/T/RBHA Contract
- R9-20-204
- R9-20-205 (B) and (C)
- R9-20-101 (15)
- R9-20-101 [17 (a) (c) (d) and (e)]
- Child and Family Team Practice Improvement Protocol
- Credentialing and Privileging Section
- Intake, Assessment and Service Planning Section
- Behavioral Health Medical Record Standard Section
- Coordination of Care with AHCCCS Health Plans and PCPs Section
- Coordination of Care with Other Government Entities Section

3.7.3 Scope

To whom does this apply?

This standard applies to all persons who are enrolled in the ADHS/DBHS behavioral health system.

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3.7.4 Definitions

Clinical Liaison

3.7.5 Objectives

The objective of this standard is to describe the roles and functions of the clinical liaison.

3.7.6 Procedures

3.7.6-A: Roles and functions of the Clinical Liaison

Each clinical liaison is responsible for the following:

- To provide clinical oversight to the team as it relates to the delivering of services for an enrolled person, including the assessment and treatment planning processes;
- To provide clinical oversight of the person's care;
- To work in collaboration with the member and his/her family or significant others to implement an effective plan, explaining the available clinical options to the team, including the advantages and disadvantages of each option;
- To serve as the point of contact, coordination and communication with other systems where clinical knowledge of the case is important;
- To ensure the clinical soundness of the assessment and treatment processes; including identifying the need for further or specialty evaluations and signing off on the person's service plan and annual assessment update;
- To provide clinical oversight to ensure provision of all covered services identified on the treatment plan; referrals to community resources as appropriate; and continuity of care between inpatient and outpatient settings, services and supports, as applicable;
- To provide continuous evaluation of the effectiveness of treatment through the ongoing assessment of the person and input from the person and relevant others resulting in modification to the treatment plan as necessary;
- To ensure the coordination of transfers out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) contractor, as applicable;
- To ensure the development and implementation of transition, discharge and aftercare plans prior to discontinuation of behavioral health services;
- To serve as a point of contact and to ensure ongoing collaboration, including the
 communication of appropriate clinical information with other individuals and/or entities with
 whom delivery and coordination of covered services is important (e.g., primary care
 providers, school, child welfare, juvenile or adult probation, other involved service
 providers). (See Section 4.3, Coordination of Care with AHCCCS Health Plans and PCPs
 and Section 4.4, Coordination of Care with other Government Agencies);
- To serve as a participating member of the person's team when applicable and possible;
- To maintain the person's comprehensive clinical record (See <u>Section 4.2, Behavioral Health Record Standard Requirements</u>), including documentation of activities performed as part of the service delivery process (e.g., assessments, provision of services, coordination of care, discharge planning); and
- To function in other capacities as appropriate and determined by the team.

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3.7.6-B: What are the requirements to be a Clinical Liaison?

A clinical liaison must either be a behavioral health professional or a behavioral health technician and meet the credentialing and privileging requirements as described in Section 3.20 Credentialing and Privileging.

3.7.6-C: Who is assigned to a Clinical Liaison?

A clinical liaison must be assigned to each enrolled person at the initial intake appointment. The clinical liaison must conduct the initial assessment and ensure that all necessary follow-up activities and transitions to subsequent services occur. It is recognized that the person assigned as the clinical liaison may change as the service plan of the person receiving behavioral health services is developed or modified. If changes in a person's clinical liaison do occur, behavioral health providers must ensure that the person's comprehensive clinical record is transitioned to the new clinical liaison (see Section 3.17, Transition of Persons).

3.7.6-D: Identification of the Clinical Liaison

Behavioral health providers must submit the name and telephone number of the person's Clinical Liaison to a centralized T/RBHA designated location. This information must be provided in a timely manner, must be accurate and updated as changes in the assignment occur. This information will contribute to coordination of care efforts with state agencies, health plans, PCPs, etc., when T/RBHAs receive inquiries regarding the identity of a person's clinical liaison.

[T/RBHA add information here regarding identification of the Clinical Liaison]

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